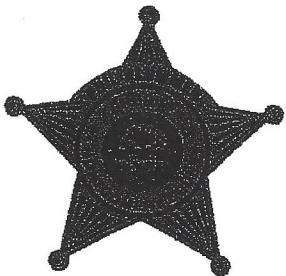


**Memorandum**



**Montgomery County Sheriff's Office  
Jail Division**

**TO:** Major Daryl Wilson

**FROM:** Captain Charles Crosby

**DATE:** May 23, 2012

**SUBJECT: In-Custody Death; Inmate Robert Richardson 12-9824**

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The attached packet outlines the circumstances surrounding the in-custody death of inmate Robert Richardson B/M 28 YOA, #12-9824. The packet contains ARS #12-4696, Jail Incident Report #12-668, video recordings documenting the staff response, witness statements completed by inmates housed in Pod D at the time of this incident, and other pertinent documentation.

**Summary**

On Saturday, May 19, 2012, at approximately 1522 hours, inmate Marcus Maxwell (12-8713) called security control using the steno system in Pod D, Cell 544, to report a medical emergency involving his cellmate Robert Richardson (12-9824). Jail staff and medical personnel responded to Cell 544 to investigate. Upon arrival at Cell 544, officers removed inmate Richardson from his cell and staff attempted to assess Richardson's medical condition; this was made difficult by Richardson's confused and combative behavior.

Several officers struggled to gain control of inmate Richardson so he could be assessed and the supervisors on the scene directed the application of wrist restraints to inmate Richardson. Medical personnel on scene observed inmate Richardson's behavior and briefed Jail Physician Dr. Ellis. Dr. Ellis issued an order to administer a shot to inmate Richardson to calm his behavior and enable medical to complete their assessment. The shot was administered by Nurse Felicia Foster at approximately 1537 hours.

Inmate Richardson was checked by jail staff and found to be in full arrest; no breath or pulse. The AED was requested, a Dayton Fire Department (DFD)



MC 1220

medic response was requested and staff present immediately began CPR on inmate Richardson. When DFD arrived in the pod, they assumed emergency care working on inmate Richardson. The CPR efforts were unsuccessful in reviving inmate Richardson. Dr. Ellis was present in the pod and made the pronouncement of death at 1608 hours.

The staff response after pronouncement included an evidence technician for photographs and a detective response by Sergeant Stephens, Detective Clymer, Detective Conley and Detective Sollenberger. Coroner's Investigator Fannin responded to conduct their investigation. Investigator Fannin notified inmate Richardson's family of his passing at 1725 by phone from my office.

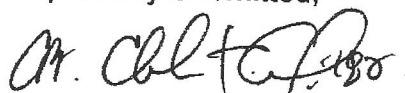
The listed timeline is based on a review of available reports and video recordings from the jail video system as recorded on May 19, 2012. The times listed here were obtained from the facility video system:

15:16:17 – Corrections Officer Benjamin leaves Pod D  
15:17:38 – Corrections Officer Benjamin re-enters pod with other officers  
15:18:30 – Camera in pod (TPZ) focused on Cell 544  
15:18:32 – additional staff and supervisor on scene (Sergeant Jackson)  
15:18:38 – inmate Richardson removed from cell; observed struggling with officers  
15:18:50 – Sergeant Lewis observed at cell  
15:18:54 – handcuffs being applied to inmate Richardson  
15:19:22 – medical staff in pod (Stockhauser and Miles)  
15:33:00 – first syringe (to administer shot) fails  
15:37:15 – shot administered by Nurse Foster  
15:40:30 – jail staff checking inmate Richardson  
15:41:11 – inmate being rolled to his back; medical called up from first level of pod  
15:41:27 – CPR started / AED requested  
15:45:25 – Dr. Ellis on scene at Cell 544  
15:49:17 – Dayton Fire Department in pod (see attached run sheet)  
16:08 - inmate Richardson pronounced by Dr. Ellis  
16:38 - Coroner's office in pod  
17:07 - inmate Richardson's body removed by coroner's office

### Conclusion

I have completed my preliminary review of this incident and did not find any violations of Office policy. I am submitting this for your review.

Respectfully Submitted,



Captain Charles Crosby  
Jail Division